New Patient Referral Form

New Patient Referral Department Contact Information
Phone: (916) 953-7571 ❖ Fax: (916) 860-7584 ❖ Email: newpatient@apdss.com

Referring Provider Information:

Provider Name ____ Provider NPI ____ Practice Name ____

Practice Contact Name ____ Phone # ____ Fax # ____ Email ____

Patient Information:

Patient Name ____ DOB ____ Phone # ____ Email ____

Patient Address, City, State, Zip ____

Insurance Type (check one)

☐ Workers' Compensation ☐ Medicare ☐ Managed Medi-Cal ☐ Med-Pay
☐ Commercial PPO/HMO ☐ Managed Medicare ☐ Personal Injury Lien ☐ Other _______________

Primary Insurance Carrier or Administrator Name ____ Patient ID or Claim # ____ Group # or Date of Accident/Injury ____

Claims Adjuster Name (if applicable) ____ Claims Adjuster Phone #, Fax # and Email (if applicable) ____

Attorney Name (if applicable) ____ Attorney Phone #, Fax # and Email (if applicable) ____

Diagnosis & Services Requested:

Primary Diagnosis Description: ____

(Please Check one):
☐ Consultation Only
☐ Consultation continued mgmt.

☐ EMG/Nerve Conduction Study
☐ Left ☐ Right
☐ Upper Extremity
☐ Lower Extremity

☐ Procedure only
☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Epidural Steroid Injection
☐ Facet Joint Injection
☐ Nerve Ablation
☐ Spinal Cord Stimulator
☐ Plasma Rich Platelet (PRP) Injection
☐ Stem Cell Injection
☐ Other: _____________________________

New Patient Referral Documentation Requirements

New Patient Referral Department Contact Information
Phone: (916) 953-7571 ❖ Fax: (916) 860-7584 ❖ Email: newpatient@apdss.com

The following documents are required in order to effectively review and consult on prospective patient care involving pain management, as well as to responsibly deliver that care, if called on to do so. Patients will not be scheduled until all requested documents have been provided.

- ☐ New Patient Referral Form
- ☐ Copy of Your Signed Medical Records Release Form (for any records held at other offices or facilities)
- ☐ Insurance authorization, if required
- ☐ List of current medications
- ☐ Diagnostic imaging from the past two years (i.e. X-Rays, MRI, CT-Scans)
- ☐ Chart notes from the last 3 visits
- ☐ Lab results pertaining referred condition (i.e. urine drug screens)
- ☐ Physical therapy evaluation notes from the past two years

Note: We are currently closed to new methadone patients**.**

Please fax all these documents to: **(916) 860-7584**

If by mail: Advanced Pain Diagnostic & Solutions
Attn: New Patient Referral Department
729 Sunrise Ave, Ste 607
Roseville, CA 95661

Thank you,

New Patient Referral Department